Form I

FORM OF APPLICATION FOR MEDICAL REIMBERSEMENT

See Rule 13 (1)

N.B. .....SEPARATES FORM SHOULD BE USED FOR EACH PATIENT

1. Name and designation of Government servant (in block letters) : .....
2. Office in which employed : .....
3. Pay of the Government Servant as defined in the : .....
   fundamental rules & any other employment which : .....
   should be shown separately : .....
4. Place of duty : .....
5. Actual residential address : .....
   : .....
6. Name of the patient and his/her relation to the : .....
   Government Servant
   [N.B. in the Case of children state age also] : .....
   1. Serial No. of child .....
   2. Date of Birth .....
   3. Total of children .....
7. Place at which the patient fell-III : .....
8. Name of illness and its duration : .....
9. Detail of the amount claimed : .....

I) MEDICAL ATTENDANCE

(i) Fees for consultation, indication : .....
   [a] The name and designation of the medical : .....
   officer consulted and the hospital or : .....
   dispensary of which attached. : .....
   [b] The number and date of consultation and : .....
   fees paid for each consultation. : .....
   [c] Whether consultation were had at the hos- : .....
   -pital at the consultation room of the medical : .....
   officer or at the residence of the patient. : .....

(ii) Charges for pathological bacteriological radiological : .....
   or other similar tests under taken during diagnosis : .....
   indicating. : .....
   [a] The name of the hospital of laboratory : .....
   where the test were under taken and. : .....
   [b] Whether the tests were under taken on the : .....
   advice of the authorized medical attendant : .....
   and if so a certificate to that effect should be : .....
   attached.

(iii) Cast of medicines purchased from the market : .....
   [List of medicines cash memos & the essentiality : .....
   certificate should be attached] : .....

II) HOSPITAL TREATMENT

Charges for hospital treatment indicating : .....
separately the charge for. : .....

(i) Accommodation(state) whether was according to the status or pay f the Government Servant and in case where the accommodating is higher than the : .....
status of the Government Servant a certificate should : .....
be attached to the effect that accommodation to which : .....
he was entilled was not available

(ii) Date : .....

(iii) Surgical operation or medical treatment : .....

(vi) Pathological, bacteriological or other similar tests indicating –

[a] The name of the hospital or laboratory : .....
which undertaken and. : .....

[b] Whether under taking on the advice of the medical officer in charge of the case at the : .....
hospital if so a certificate to the eddect : .....
should be attached.

(v) Medicines : .....

(vi) Special medicine

[List od medicines cash memos and the : .....
essentility certificate should be attached .

(vii) Ordinary nursing : .....

(viii) Special nursing i.e. nurses specially engages for the Patient stet whether they were employed on : .....
advise of the medical officer in Government
Servant or patient on the farmer case a certificate : .....
from the M.O. 1/c of the ease & countersigned by
the medical superintendent of the hospital be attached.

(ix) Any other charges, e.g. charges for electric light fan hearer air conditioning etc. state also whether : .....
facilities refierd to a part of the facility normally : .....
provided to all patient and no choices was last to patient.

Note – if the treatment was received by the Government : .....
Servant at his residence give particulars of such : .....
treatment and attached a certificate from the
authorized medical attendant.

(x) Total amount claimed : .....

(xi) List of enclosures : .....

DECLARATION TO BE SIGNED BY GOVERNMENT SERVANT

I here by declare that the statement in the application are true to the best of my knowledge and belief & that person for whom medical expenses were included is wholly dependent upon me.

Signature of the Government Servant
& officer to which attached.

Form II

FORM OF ESSENTIALITY CERTIFICATE

See Rule 13 (2)

A- IN CASE OF MEDICINES NOT INCLUDED IN THE PRICES VOCABULARY OF THE MEDICAL STORES DEPOT

Certified that Shri/Shrimati/Kumari ……...

Son/wife/Daughter of Shri ……..

employed in the ……..

has been under my treatment from …… to ……..

for .....(name of the disease) at the

…….. hospital as in door/out door patient and that the undermentioned medicine have been prescribed by me in this connection the medicines are not included in prices vocabulary of the Medical Stores nor are the preparations which are primarily foods toilets or disinfectants. These medicines were absolutely essential for treatment of the aforesaidpatient.

NAME OF MEDICINES

	Name of the Medicines	Quantity	Cost .
01.			
02.			
03			
04			
05			
06			
07			
08			
09			
10			
11			
12			
13			
14			
15			

CERTIFICATE

This is to certify the Medicines presented out of P.V.M.S. list essential to the patient.

……

Signature and designation of the authorized medical attendant

Signature of the medical officer 1/c of case at the hospital

B- IN CASE OF MEDICINES INCLUDED IN THE PRICES VOCABULARY OF THE MEDICAL STORES DEPOT

Certified that Shri/Shrimati/Kumari ……...

Son/wife/Daughter of Shri ……..

employed in the ……..

has been under my treatment from …… to ……..

for .....(name of the disease) at the

…….. hospital as in door/out door patient and that the undermentioned medicine have been prescribed by me in this connection. These medicines are in the priced vocabulary of the Medical Stores and are out of stock not available the …… …… hospital. They do not include any medicines proprietor of otherwise outside the a foreside priced vocabulary out and preparations which are primarily foods of disinfectants preparations which are primarily foods toilets or disinfectants.

Name of the Medicines	P.V.M.S. No.	Cost .
01.		
02.		
03		
04		
05		
06		
07		
08		
09		
10		
11		
12		
13		
14		
15		

……

Signature and designation of the authorized medical attendant

Signature of the medical officer 1/c of case at the hospital